

Protecting, Maintaining and Improving the Health of All Minnes ot ans

Electronically delivered September 28, 2020

Administrator Good Samaritan Society - Woodland 100 Buffalo Hills Lane Brainerd, MN 56401

RE: CCN: 245488

Cycle Start Date: July 24, 2020

Dear Administrator:

On August 5, 2020, we notified you a remedy was imposed. On August 26, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 17, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective August 22, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 5, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 22, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 17, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 28, 2020

Administrator Good Samaritan Society - Woodland 100 Buffalo Hills Lane Brainerd, MN 56401

Re: Reinspection Results

Event ID: 7IIR12

Dear Administrator:

On August 26, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 24, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 7, 2020

Administrator Good Samaritan Society - Woodland 100 Buffalo Hills Lane Brainerd, MN 56401

RE: CCN: 245488

Cycle Start Date: July 24, 2020

Dear Administrator:

On July 24, 2020, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 22, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 22, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 22, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 22, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Woodland will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 22, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor Email: lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 24, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 08/19/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	COM	E SURVEY IPLETED
		245488	B. WING				C 24/2020
	PROVIDER OR SUPPLIER	- WOODLAND		10	TREET ADDRESS, CITY, STATE, ZIP CODE 10 BUFFALO HILLS LANE RAINERD, MN 56401	<u> </u>	- 11/2020
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F 000	INITIAL COMMEN	ΤS	F0	00			
	was completed at y complaint investiga not to be in compliant.	24/20, an abbreviated survey vour facility to conduct a ution. Your facility was found ance with 42 CFR Part 483, and Term Care Facilities.			Past noncompliance: no plan of correction required.		
	The following comp substantiated:	plaint was found to be					
	H5488020C: Deficiency issued at F689						
	as your allegation of Department's accessorial enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.					
	on-site revisit of you validate that substate regulations has been your verification. Free of Accident Ha	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with	F 6	89			8/17/20
SS=G		nts.					
	supervision and as accidents.	resident receives adequate sistance devices to prevent					
ABORATOR\	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

08/17/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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F 689	Based on intervier facility failed to im interventions to re residents (R1) revactual harm when resulting in laceral knee. In addition, assess for the roo and failed to impleresidents (R3) revenues findings include: R1's quarterly Min 4/27/20, indicated impaired, required staff for bed mobilitotal assistance from MDS indicated R1 assessment. R1's (CAA) dated 11/7/maintaining sitting balance during traidentified poor ins and R1 remained R1's Care Plan dacare deficit and dibaths due to fall rife 7/21/20, to include safety belt. The cato include staff to indicated tub or befurther identified a of putting herself of impaired mobility adirected the use of the safety belt.	w and document review, the plement care planned duce the risk of falls for 1 of 3 iewed for falls. This resulted in R1 fell from a shower chair tions to her forehead, lip and the facility failed to thoroughly t and identify a pattern of falls ement interventions for 1 of 3 iewed for falls. imum Data Set (MDS) dated she was severely cognitively extensive assistance from two ity, transfers and toileting and om one staff for bathing. The had no falls since the previous Falls Care Area Assessment 19, indicated she had difficulty balance and had impaired nsfers. The CAA further ight and no safety awareness	F 6	1. Resident 1's injuries treate emergency department. Thera assessed resident on 7/29 to deproper shower chair positioning interventions to reduce the risk was reviewed and care plan up Employee suspended pending investigation at time of incident Employee received re-education precautions and bathing assist before return. Resident #3 had a toileting assessompleted on 6/11/20, no chain needed at time. Toileting assessompleted on 6/18/20 and care updated. Toileting assessoment on 6/25/20. Care plan reviewed changes needed. Root cause a completed on 8/11/20. Bladder assessment incontinence data tool being completed on 8/14/2 plan updated with new program assessment recommendations Medication review completed oby consultant pharmacist. Med suggestions sent to MD on 8/1 awaiting MD decision for imple 2. All shower chair assisted be suspended until staff had educ policy and procedure and safet use. All residents fall interventito bathing assistance via show were reviewed and care plans needed. All residents' interventing the plans needed were care any changes needed were care	etermine g. Care plan of falls dated. of R1. on on safety ance essment ges sment plan completed I and no analysis collection 0. Care n . n 8/13/20 feation 4/20 mentation. athing was ation on y device ons relating er chair updated as tions to viewed and e planned.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	` ´COM	(X3) DATE SURVEY COMPLETED	
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F 689	dated 7/19/20, indic from one staff for be shower with the safe for safety. On 7/23/20, at 9:56 in a tilt in space who was noted to have eyes and forehead cut was also noted A facility incident real cut was receiving a shower chair. NA-Aentered the shower R1 was lying on the blood coming from knee. R1 complain A facility Progress R1 fell out of the shows was found to have laceration on right laceration on her ut the hospital.	cated R1 required assistance that ing and she could receive a fety belt on the shower chair a.m. R1 was observed seated eelchair in her room. R1's face red/purple bruising around her extending into her hairline. A on her upper lip. Export dated 7/20/20, indicated a shower when she fell from the a called for help and writer room to find R1 on the floor. Endor on her right side with her forehead, top lip and right ed of her head hurting. Note dated 7/20/20, indicated nower chair at 5:10 p.m. She a laceration on her forehead, knee and a bruise and pper lip. R1 was transferred to	F 689	,	ning " policy e bathing e ical skill ssistance. /20 and ations via be ing tools an. All bathing ny stance no ient. y incident complete sing staff		
	fall. While in the sh and R1 fell forward was care planned t the chair and staff A facility document dated 7/20/20, indice	am (IDT) met to review R1's ower chair, staff turned away from the shower chair. R1 to have a seat belt on while in had not put the belt on. titled Investigation Interview cated NA-B stated the brakes on the shower chair were		4. Random audits during bathin will be completed by QAPI coordidesignee, five times/week for 4 warious times to ensure care plar interventions are being followed. audits will occur 2 times/week for and then 1 time/week for 4 weeks Results will be forwarded to the Committee for further recommend.	nator or veeks at Random 4 weeks s. QAPI		

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F 689	NA-C's Investigat indicated she did chair and indicate who needed a sar further stated the not work very well NA-D's Investigat indicated she had the use of seat be Licensed practical Interview indicate required the use of seat be Licensed practical Interview indicate required the use of shower chair. During interview of maintenance directly shower room of the MD stated proportion of the buildings maintenance directly shower chair shower chairs froom inspection of maintenance directly shower chairs froom inspection of the buildings maintenance directly shower chairs froom inspection of the buildings maintenance directly shower chairs froom inspection of the buildings maintenance directly shower chairs froom inspection of the stated R1 had always that was initiated investigating R1's indicated investigating R1's indicated indicated investigating R1's indicated ind	ion Interview dated 7/20/20, not know how to use the shower of she had not been trained on fety belt while in the chair. NA-A brakes on the shower chair did	F 6	Audit will be completed on a ensure GSS 409 and 415 was a team and any informat determine root cause is not ensure that review was consafety incident managemer ensure interventions are apreduce the risk of injury or state of Compliance: Automatical Automatic	vere completed tion to help ted. It will also appleted in the at tool to appropriate to serious harm.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 689	belts when a reside chairs. At that time directed staff not to provided education procedures and init training to be compuse a shower chair that had not complecould only use the received training procedures are following the incide. During interview or stated she was not belt while in the shot training, she was owhirlpool and had rof the shower chair shift staff only got a receive a bath and receive. When ask Kardex, NA-C state the Kardex is." NA-work she was required procedures related allowed to give shoc chairs were obtaine R3's admission MER3's diagnoses incacute kidney failured difficulty walking, when the MDS also indicterm memory imparting, and displayerbal or other behoare or wandering.	ent was seated in the shower, the DON said the facility had of use the shower chairs, and the the policies and tiated a return demonstration pleted before the staff could ragain. The DON stated staff eted the return demonstration whirlpool. She stated NA-C rior to returning to work ent. 1. 7/24/20, at 11:02 a.m. NA-C aware R1 needed a lap (seat) ower chair. NA-A stated during only trained on using the not received training on the use as. NA-C said at the start of the a list of who was scheduled to what type of bath they were to ed about the use of the ed, "I actually don't know where acc stated prior to returning to ired to review the policies and to bathing and had not been owers until the new shower	F6	688			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C			
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F 689	R3's Cognitive CAA had memory impair affected day to day due to R3 self translimitations. R3's Ur Indwelling Cathete R3 was incontinent inconsistent with reneeds, even when R3's Care Plan dat of 6/21/20, indicate impaired mobility, and to The Care Plan indicate impaired mobility, and would often rethe care plan indicate and would often rethe care plan indicate and would often rethe care plan directed to repick up dropped ite in activities that proceed was wearing processed when in bed directed staff to plate bed, non-skid striptand to monitor R3. Review of R3's clint following: -Incident report dat was found lying on pants down. R3 striptants of the	A dated 6/02/20, indicated R3 rment and dementia which tasks and created a fall risk sferring and forgetting his inary Incontinence and CAA dated 6/02/20, indicated to bladder daily and was ecognizing his own toileting wet. ed 5/21/20, with revision date and a high risk for falls related to weakness and history of falls. Cated R3 self transferred, had ations, did not use his call light fuse assistance with cares. Cated due to the self transfers, falls, but indicated further ons were felt to be too did cause more harm than good. Cated staff to continue to make as asfe and reduce falls. Staff mind R3 not to bend over to ems, encourage to participate oper foot wear and gripper. The care plan further use pancake button on R3's so on floor in front of the toilet	F 68	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	` '	(X3) DATE SURVEY COMPLETED	
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F 689	was anxious and to refused staff assist to walk in the hall. bed and while staff lost his balance and wearing gripper so injuries. Intervention bed to alert staff or out of bed and staff or out of b	ted 6/13/20, at 2:00 a.m. R3 rying to get out of bed, but tance. Staff accompanied R3 R3 was ambulated back to f was straightening his bed, R3 d fell backwards. R3 was cks and had a gait belt on. No ons: pancake button placed on f any attempts R3 made to get ff to monitor R3 hourly. ted 6/19/20, at 7:30 p.m. R3 the floor in his room. R3 had nd his call light and pancake R3 stated he was going to the ries. No interventions were re Plan was updated for R3 to njury of falls. R3 was mobile, pendent minded. Physical x baseline, other material of be invasive and would cause	F 68	9			
	enter R3's room for bathroom. RN-A win the room and so	22 a.m. RN-A was observed to allowing his request to go to the was unable to locate a gait belt be exited the room to find one. be gone a half hour or more,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	- WOODLAND		STREET ADDRESS, CITY, STATE, ZIP C 100 BUFFALO HILLS LANE BRAINERD, MN 56401	•	2-112020
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F 689	they always say a cup to be a long time the bathroom, you j returned and started and with hand hygicand with hand hygicand to enter Form to offer to take him noon meal. R3 reputation bathroom first. DA-At 12:01 p.m. NA-Alooked into the roomand after gloving, assisted R3 hygiene. At 12:05 p.m. DA-At 12:05 p.m.	ouple of seconds but it ends a, and when you have to go to ust can't wait that long. RN-A d to assist R3 to the bathroomene. Stary aide (DA)-A was R3's room and was overheard into the dining room for his lied he had to go to the A left the room without reply. A knocked on R3's door and and then left. Was observed to have onto the toilet in his bathroom. In and the toilet in his bathroom. In a d to assist R3. NA-A entered washing his hands and S3 with toileting and hand A confirmed R3 had requested and washing his hands and S4 confirmed R3 had requested and verified he had not aff of R3's request. a.m. R3 was observed ack to his room following	F 68	89		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	COM	E SURVEY IPLETED
		245488	B. WING				C 24/2020
	PROVIDER OR SUPPLIER	- WOODLAND		100	EET ADDRESS, CITY, STATE, ZIP CODE BUFFALO HILLS LANE AINERD, MN 56401	1 017	2-1/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	-At 9:46 a.m. NA-A washing his hands R3 to complete toil stated the staff tries as they could, but the exceptionally busy "We are doing the thought R3 was on would have to check care to be sure. Not stated R3 was to be was on hourly monhad to document enthe Kardex to record think of anyone and that they pretty every two hours. -At 10:00 a.m. RN-intervention after enthey would add and so on. RN-B stated chosen based on homeone rolled out mat. RN-B stated R3. After reviewing admission, RN-B convolved toileting and toileting schedule rintervention for R3.	entered R3's room and after and applying gloves, assisted eting and hand hygiene. NA-A d to check on R3 as frequently he call lights were that morning. NA-A stated, best we can." NA-A stated he two hour checks but that he two hour checks but that he k R3's Kardex and plan of A-A checked R3's Kardex and et oileted every two hours and itoring. NA-A stated the aides ach check they performed on they were doing them. stated she would look on the teach resident needed and ansfer. She stated she could on a specific toileting program much toileted every resident. B stated they add an ach fall and if that did not work other one and another one and d the interventions were ow the resident fell, such as if it of bed, they would add a fall a fall mat would not work with g all of R3's falls since onfirmed all but one fall and stated she did feel a may be an appropriate	F	889			
	was at home. The	DON stated he was just a received therapy, but					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245488	B. WING			C / 24/2020
	PROVIDER OR SUPPLIER	- WOODLAND		STREET ADDRESS, CITY, STATE, ZI 100 BUFFALO HILLS LANE BRAINERD, MN 56401		12412020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	continued to transfer the call light appropriassistance. The Dot two hour toileting so looked at his toileting DON confirmed and tailored to R3's need in addition, the DOI staff should have not and had been educed future. -At 1:29 p.m. the Doi bowel and bladder completed on 6/3/2 another assessmer identify a potential retoileting needs and to developing and implemed occurred. The policy, dated 6/24/2 which included: to developing and implemed occurred. The policy as a method for idea problem so that the identified and put in staff to review admirisk factors and to developing and to control to the policy.	or independently, did not use briately and did not ask for ON stated R3 was on an every chedule however, they had not ag needs that closely. The more specific toileting schedule ds, may prevent some falls. N confirmed that the dietary officed nursing of R3's request ated on what to do in the ON confirmed that while a cassessment had been 0, following admission, at was not initiated in order to relationship between R3's	F 6	89		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 7, 2020

Administrator Good Samaritan Society - Woodland 100 Buffalo Hills Lane Brainerd, MN 56401

Re: State Nursing Home Licensing Orders

Event ID: 7IIR11

Dear Administrator:

The above facility was surveyed on July 23, 2020 through July 24, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lyla Burkman, Unit Supervisor Email: lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
							С	
		00956		B. WING		07/2	24/2020	
NAME OF	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WOODLAND		FALO HILLS RD, MN 5640				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 000	Initial Comments			2 000				
	*****ATTE	NTION*****						
	NH LICENSING	CORRECTION OR	DER					
	In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Depart	ction order has beer y. If, upon reinspectiency or deficiencies ected, a fine for each be assessed in accornes promulgated b	n issued ction, it is s cited h violation ordance					
	Determination of whe corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	compliance with all rule provided at the le rule provided at the le number indicated as several items, faithe items will be concard to Lack of compliancing item of multi-parment of a fine even	e tag d below. ilure to nsidered e upon t rule will if the item					
	You may request a that may result from orders provided tha the Department with notice of assessme	n non-compliance w t a written request i hin 15 days of recei	rith these s made to pt of a					
	INITIAL COMMENT On 7/23/20 and 7/2 was conducted to d State Licensure. Yo be in compliance w	4/20, an abbreviate etermine compliand ur facility was found	ce with					
	The following comp with a licensing ord		bstantiated					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 08/17/20

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00956		B. WING			C 24/2020
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WOODLAND	100 BUFF	DRESS, CITY, S ALO HILLS I D, MN 5640			
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2 000	Continued From pa	ge 1		2 000			
	The facility is enrolle signature is not required, it is required to receipt of State lices the Minnesota Department of State lices the Minnesota Department of State lices that the Minnesota Department of State licensing attached Minnesota Deing submitted to no plan of correction Statutes/Rules, pleasing the box available indicate in the elect under the heading corders will be correct submitting to the Minnesota Department of State of S	uired at the bottom Although no plan of uired that the facility of the electronic of participate in the ensure orders consider the ensure orders consider the ensure of Health in 14-01, available eate.mn.us/divs/fpc, orders are delineated Department of Health in secessary for Sease enter the word for text. You must ronic State licensure completion date, the cted prior to electronic state.	of the first of correction by documents. Electronic stent with at profinfo/info ted on the alth orders Although State "corrected" then the process, the date your mically				
	Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes.	Correction Orders ig numbers have be	using een				
	The assigned tag not column entitled " IE statute/rule out of column statements and replaces the "To correction order. The	O Prefix Tag." The ompliance is listed nt of Deficiencies" o Comply" portion of	state in the column of the				

Minnesota Department of Health

STATE FORM 6899 7IIR11 If continuation sheet 2 of 12

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	X3) DATE SURVEY COMPLETED		
			A. BUILDING:		c	
		00956	B. WING		07/24/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WOODI AND	ALO HILLS D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 000	after the statement evidence by." Followare the Suggested Time period for Conplex PLEASE DISREGATOURTH COLUMN "PROVIDER'S PLAAPPLIES TO FEDE THIS WILL APPEATHERE IS NO RECOPLAN OF CORRECT	in violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.	2 000			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must be and treatment, personal and supervision based on a preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident	2 830		8/17/20	
	by: Based on interview facility failed to imp	and document review, the lement care planned uce the risk of falls for 1 of 3		Resident 1's injuries treated in emergency department. Therapy assessed resident on 7/29 to deterr	nine	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		00956	B. WING		07/24/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
COOD C	AMADITAN COCIETY	WOODLAND 100 BUFF	ALO HILLS	LANE		
GOOD 3	AMARITAN SOCIETY	- WOODLAND BRAINERI	D, MN 5640	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
2 830	Continued From pa	ge 3	2 830			
	actual harm when F resulting in laceration knee. In addition, the assess for the root	ewed for falls. This resulted in R1 fell from a shower chair ons to her forehead, lip and he facility failed to thoroughly and identify a pattern of falls ment interventions for 1 of 3 ewed for falls.		proper shower chair positioning. Conterventions to reduce the risk of reviewed and care plan updated. Employee suspended pending investigation at time of incident of Employee received re-education of precautions and bathing assistant return.	falls was R1. on safety	
	R1's quarterly Minir 4/27/20, indicated s impaired, required staff for bed mobilit total assistance from MDS indicated R1 I assessment. R1's F (CAA) dated 11/7/1 maintaining sitting balance during transparents.	mum Data Set (MDS) dated she was severely cognitively extensive assistance from two y, transfers and toileting and m one staff for bathing. The had no falls since the previous falls Care Area Assessment 9, indicated she had difficulty balance and had impaired sfers. The CAA further light and no safety awareness t risk for falling.		Resident #3 had a toileting assess completed on 6/11/20, no changes at time. Toileting assessment com on 6/18/20 and care plan updated Toileting assessment completed of 6/25/20. Care plan reviewed and richanges needed. Root cause and completed on 8/11/20. Bladder assessment incontinence data coltool being completed on 8/14/20. It is plan updated with new program assessment recommendations. Medication review completed on 8/14/20. On the second review c	s needed pleted . on no lysis lection Care	
	care deficit and dire baths due to fall rist 7/21/20, to include, safety belt. The car to include staff to prindicated tub or bed further identified a rof putting herself or impaired mobility and directed the use of Dycem in recliner, at A nursing assistant dated 7/19/20, indicated from one staff for be	ed 5/12/20, indicated a self ected staff to provide whirlpool k. The care plan was updated could have showers with e plan was revised on 7/23/20, rovide bathing assistance and d bath for safety. The care plan risk for falls related to a history in the floor to look for things, and impaired cognition and a tilt in space wheel chair, a wheel chair and a low bed. (NA) care guide (Kardex) cated R1 required assistance athing and she could receive a fety belt on the shower chair		suggestions sent to MD on 8/14/2 awaiting MD decision for impleme 2. All shower chair assisted bath suspended until staff had education policy and procedure and safety duse. All residents fall interventions to bathing assistance via shower of were reviewed and care plans uponeeded. All residents' intervention reduce the risk of falls were review any changes needed were care plans uponeeded. All residents' intervention reduce the risk of falls were review any changes needed were care plans uponeeded. Residents noted to be at risk for fralls were reviewed to ensure apprenticed.	ontation. ing was on on evice relating chair dated as as to eved and anned. A on	

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		00956	B. WINO		07/24	/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WOODLAND	ALO HILLS D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	for safety.			root cause had identified and care interventions.	planned	
	in a tilt in space who was noted to have eyes and forehead cut was also noted A facility incident re R1 was receiving a shower chair. NA-A entered the shower R1 was lying on the blood coming from knee. R1 complaine A facility Progress NR1 fell out of the shows found to have a laceration on right klaceration on her up the hospital. Progress Note date interdisciplinary tea fall. While in the shoand R1 fell forward	ea.m. R1 was observed seated eelchair in her room. R1's face red/purple bruising around her extending into her hairline. A on her upper lip. port dated 7/20/20, indicated shower when she fell from the called for help and writer room to find R1 on the floor. If floor on her right side with her forehead, top lip and right ed of her head hurting. Note dated 7/20/20, indicated hower chair at 5:10 p.m. She a laceration on her forehead, knee and a bruise and oper lip. R1 was transferred to ed 7/21/20, indicated the m (IDT) met to review R1's ower chair, staff turned away from the shower chair. R1 o have a seat belt on while in		3. All staff re-educated on "Bathi nursing services" and "Restraints" and procedures. All staff that give assistance were determined to be competent by completing the clinic checklist prior to providing this ass All staff to have reeducation on 8/2 8/21 on finding care plan intervent Kardex. Licensed nursing staff to reeducated on proper care plannir to pull interventions to the care pla staff will be reeducated on proper positioning and who to notify of an change in condition making assist longer appropriate for reassessme. IDT was reeducated on the safety management tool and its use to coa root cause after each fall. Nursi to be educated on Fall policy and procedures and close calls. 4. Random audits during bathing will be completed by QAPI coording designee, five times/week for 4 weeks.	cal skill sistance. 20 and cions via be ng tools an. All bathing by ance no ent. incident omplete ng staff	
	the chair and staff h	nad not put the belt on.		various times to ensure care plan interventions are being followed. F	Random	
	dated 7/20/20, indic	titled Investigation Interview cated NA-B stated the brakes on the shower chair were		audits will occur 2 times/week for and then 1 time/week for 4 weeks will be forwarded to the QAPI comfor further recommendation.	. Results	
	indicated she did no chair and indicated who needed a safe	n Interview dated 7/20/20, ot know how to use the shower she had not been trained on ty belt while in the chair. NA-A rakes on the shower chair did		Audit will be completed on every far ensure GSS 409 and 415 were coas a team and any information to lidetermine root cause is noted. It wensure that review was completed	mpleted help vill also	

Minnesota Department of Health

STATE FORM 6899 7IIR11 If continuation sheet 5 of 12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.				
		00956		B. WING		07/2	; 4/2020
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
				ALO HILLS	,		
GOOD S	AMARITAN SOCIETY	- WOODLAND		D, MN 5640			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENC		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
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2 830	Continued From pa	ge 5		2 830			
	not work very well. NA-D's Investigation				safety incident management too interventions are appropriate to risk of injury or serious harm.		
	indicated she had n the use of seat belts				5. Date of Compliance: August	22, 2020	
	Licensed practical nurse (LPN)-A's Investigation Interview indicated she was not aware R1 required the use of a seat belt when seated in the shower chair.						
	During interview on 7/24/20, at 9:51 a.m. the maintenance director (MD) was observed in the facility shower room inspecting the shower chairs. The MD stated prior to R1's fall in the tub room, no regular inspections of the shower chairs had been completed and stated they were only inspected if someone reported an issue. The MD stated since R1's fall, routine safety inspections of the bathing equipment had been integrated into the buildings maintenance management system. Upon inspection of the shower chairs, the maintenance director removed one of three shower chairs from the tub room and stated the chair had loose PVC pipes and no safety seatbelt.						
	At 10:15 a.m. the di stated R1 had alwa sustained multiple f stated R1 had a pre chair which was wh chair was initiated. investigating R1's restaff were not award belts when a reside chairs. At that time, directed staff not to provided education procedures and init training to be comp	ys been a fall risk a falls in the past. The evious fall out of the en the seat belt in the DON stated where the need to use the DON said the fall, it was deen the need to use the bon said the fall use the shower chon the the policies iated a return demonals.	and had e DON e shower the shower nile termined e the seat e shower facility had airs, and onstration				

Minnesota Department of Health

AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00956		B. WING			C 24/2020
	PROVIDER OR SUPPLIER	- WOODLAND	100 BUFF	DRESS, CITY, S ALO HILLS I D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	use a shower chair that had not comple could only use the vice received training price following the incider During interview on stated she was not belt while in the shot training, she was or whirlpool and had not the shower chairs shift staff only got a receive a bath and receive. When aske Kardex, NA-C state the Kardex is." NA-work she was requiprocedures related allowed to give shochairs were obtained R3's admission MD R3's diagnoses including the shower chairs was since the sidney failure difficulty walking, were obtained to give shochairs were obtained acute kidney failured difficulty walking, were simple to show that is the sidney failured difficulty walking, were obtained to give show that is the sidney failured difficulty walking, were obtained to give show that is the sidney failured difficulty walking, were shown that is the sidney failured difficulty walking, were shown that is the sidney failured to give show that is the sidney failured difficulty walking, were shown that is the sidney failured to give show that the sidney failured to give show that is the sidney failured to	again. The DON stated the return demonstrated the return demonstrated the return demonstrated to returning to wort. 7/24/20, at 11:02 at aware R1 needed a lower chair. NA-A stanly trained on using not received training s. NA-C said at the stated what type of bath the dabout the use of ed, "I actually don't keed about the use of ed, "I actually don't keed to review the potto bathing and had wers until the new seed. S dated 5/26/20, included urinary tract in ed, diabetes mellitus, eakness and history eated R3 had short a firment, impaired delyed no psychosis, playing required limited.	onstration d NA-C ork .m. NA-C alap (seat) alap (seat) atted during the on the use start of the eduled to ey were to the now where urning to blicies and not been hower dicated affection, dementia, of falling, and long acision hysical, ection of assistance	2 830			
	due to R3 self trans limitations. R3's Uri	ment and dementia tasks and created a ferring and forgettir	which a fall risk ng his nd				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		00956	B. WING		07/2	4/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WOODI AND	ALO HILLS I D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
	R3 was incontinent inconsistent with re	of bladder daily and was cognizing his own toileting				
	needs, even when wet. R3's Care Plan dated 5/21/20, with revision date of 6/21/20, indicated a high risk for falls related to impaired mobility, weakness and history of falls. The Care Plan indicated R3 self transferred, had no idea of his limitations, did not use his call light and would often refuse assistance with cares. The care plan indicated due to the self transfers, R3 had numerous falls, but indicated further physical interventions were felt to be too restrictive and could cause more harm than good. The care plan directed staff to continue to make attempts to keep R3 safe and reduce falls. Staff were directed to remind R3 not to bend over to pick up dropped items, encourage to participate in activities that promoted exercise and ensure R3 was wearing proper foot wear and gripper socks when in bed. The care plan further directed staff to place pancake button on R3's bed, non-skid strips on floor in front of the toilet					
	Review of R3's clin following:	ical record revealed the				
	-Incident report dated 6/9/20, at 10:41 p.m. R3 was found lying on the bathroom floor with his pants down. R3 stated he must have fallen. No injury. Intervention: gripper socks on at all times and non-skid strips to R3's bathroom floor.					
	was anxious and treefused staff assist to walk in the hall. bed and while staff	ed 6/13/20, at 2:00 a.m. R3 ying to get out of bed, but ance. Staff accompanied R3 R3 was ambulated back to was straightening his bed, R3				

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STATE FORM 6899 7IIR11 If continuation sheet 8 of 12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00956		B. WING			C 24/2020
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WOODLAND	100 BUFF	ALO HILLS		·	
			BRAINER	D, MN 5640	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI / MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ae 8		2 830			
	wearing gripper socinjuries. Intervention bed to alert staff of out of bed and staff -Incident report date was found lying on gripper socks on an	cks and had a gait bons: pancake button any attempts R3 m to monitor R3 hour ed 6/19/20, at 7:30 the floor in his room hd his call light and	placed on ade to get ly. p.m. R3 n. R3 had pancake				
	light had alerted. R bathroom. No injur identified. The Care remain free from injumpulsive and indeptherapy was at maxinterventions felt to more distress than	ies. No intervention e Plan was updated jury of falls. R3 was bendent minded. P t baseline, other ma be invasive and wo	ns were I for R3 to s mobile, hysical iterial				
	-Incident report dated 7/17/20, at 2:50 p.m. R3 was found lying on the bathroom floor. R3 stated he was trying to get to the restroom and lost his balance. No injuries. No interventions identified. R3's clinical record lacked comprehensive assessments and identified interventions to address the falls which occurred on 6/19/20 and 7/17/20.						
	On 7/23/20, at 11:2: enter R3's room foll bathroom. RN-A win the room and so R3 stated she will be they always say a cup to be a long time the bathroom, you jireturned and started and with hand hygie -At 11:58 a.m. a die observed to enter R to offer to take him	lowing his request the sunable to locate exited the room to be gone a half hour ouple of seconds be, and when you have ust can't wait that loud to assist R3 to the ene. Stary aide (DA)-A was also room and was also located to the ene.	o go to the a gait belt find one. or more, ut it ends ve to go to ong. RN-A e bathroom as overheard				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTII A. BUILDIN	l` 'c	(X3) DATE SURVEY COMPLETED	
00956 B. WING _		C 7/24/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WOODLAND STREET ADDRESS, CITY 100 BUFFALO HILLS BRAINERD, MN 564	S LANE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 830 Continued From page 9 noon meal. R3 replied he had to go to the bathroom first. DA-A left the room without replyAt 12:01 p.m. NA-A knocked on R3's door and looked into the room and then leftAt 12:02 p.m. R3 was observed to have transferred himself onto the toilet in his bathroom. NA-A was requested to assist R3. NA-A entered the room and after washing his hands and gloving, assisted R3 with toileting and hand hygieneAt 12:05 p.m. DA-A confirmed R3 had requested to go to the bathroom and verified he had not informed nursing staff of R3's request. On 7/24/20, at 9:36 a.m. R3 was observed wheeling himself back to his room following breakfast in the dining room. -At 9:41 R3 was observed to have self transferred himself to the toilet in his bathroom. RN-B was asked to assist R3 in the bathroom. RN-B confirmed R3 was not safe to transfer alone and called for an aide to assist R3 but was informed the aides were all occupied assisting other residents. RN-B entered R3's bathroom to assist him with completing his toileting however, R3 stated he would need more time. RN-B handed R3 his bathroom pull cord and instructed R3 to ring for assistance when he was finished. RN-B then left the room. -At 9:46 a.m. NA-A entered R3's room and after washing his hands and applying gloves, assisted R3 to complete toileting and hand hygiene. NA-A stated the staff tried to check on R3 as frequently as they could, but the call lights were exceptionally busy that morning. NA-A stated,			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	00956		B. WING			C 07/24/2020	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE		
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GOOD S	AMARITAN SOCIETY	- WOODLAND	BRAINER	D, MN 5640	1		
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2 830	Continued From pa	ge 10		2 830			
	care to be sure. Na stated R3 was to be was on hourly monihad to document eathe Kardex to recorn. At 9:50 a.m. NA-B Kardex to see what how they were to tranot think of anyone and that they pretty every two hours. -At 10:00 a.m. RN-I intervention after eathey would add and so on. RN-B stated chosen based on his someone rolled out mat. RN-B stated a R3. After reviewing admission, RN-B co involved toileting ar toileting schedule mintervention for R3.	e toileted every two toring. NA-A stated ach check they performed they were doing the stated she would lot each resident need ansfer. She stated on a specific toileting much toileted every as stated they add are ach fall and if that dither one and anothed the interventions wow the resident fell, of bed, they would a fall mat would not gall of R3's falls since on firmed all but one and stated she did feet	hours and the aides ormed on hem. ok on the led and she could he program or resident of not work er one and were such as if add a fall work with ce fall el a				
	-At 10:50 a.m. the I of falls at his previo was at home. The frequent faller, had continued to transfethe call light appropassistance. The DO two hour toileting so	us facility as well as DON stated he was received therapy, ber independently, did riately and did not a DN stated R3 was o	when he just a ut I not use ask for nan every				
	looked at his toileting DON confirmed a nation tailored to R3's need in addition, the DOI staff should have not and had been educated.	ng needs that closely nore specific toiletin ds, may prevent so N confirmed that the otified nursing of R3	y. The g schedule me falls. dietary 's request				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			B WINC			С	
		00956		B. WING		07/2	24/2020
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WOODLAND		ALO HILLS I D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From paragraphs future. -At 1:29 p.m. the Dobowel and bladder a completed on 6/3/2 another assessment identify a potential resolution to letting needs and. The facility Fall Prespolicy, dated 6/24/2 which included: to developing and impland management procurred. The policias a method for ide problem so that the identified and put in staff to review admirisk factors and to dinterventions, included: SUGGESTED MET The director of nurse review and/or revise related to falls and dinterventions, education to the composition of the problem in the composition of the compo	ON confirmed that assessment had be 0, following admiss at was not initiated elationship betwee falls. I wention and Manago 0, identified five purporter resident was lementing a fall program and to iderent interventions be best solutions countifying the causes best solutions count to place. The policies and procession documentations are plan the appropriate appropriate sould develop monition on the policies and processes are processes and processes and processes and processes and processes and processes and processes are processes and processes and processes and processes are processes are processes are processes are processes and processes are proces	gement arposes yell-being by evention hitfy risk efore a fall se analysis of the all areas. CTION: gnee could edures a of fall staff. The toring e and we group for	2 830	DEFICIEN		

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